Available online at www.sciencedirect.com
SCIENCE DIRECT®
Health Policy 76 (2006) 169–178
HEALTH policy
www.elsevier.com/locate/healthpol

Prevalence and content of written ethics policies on euthanasia in Catholic healthcare institutions in Belgium (Flanders)

Chris Gastmans *, Joke Lemiengre, Gerrit van der Wal, Paul Schotsmans, Bernadette Dierckx de Casterlé

Katholieke Universiteit Leuven, Centre for Biomedical Ethics and Law, Kapucijnenvoer 35, Leuven 3000, Belgium

Abstract

Background: Euthanasia is performed worldwide, regardless of the existence of laws governing it. Belgium became the second country in the world to enact a law on euthanasia in 2002. Healthcare institutions bear responsibility for guaranteeing the quality of care for patients at the end of life, and for ensuring support for caregivers involved. Therefore, institutional ethics policies on end-of-life decision-making, especially on euthanasia, may be useful.
Methods: A cross-sectional mail survey of general directors of Catholic hospitals and nursing homes in Belgium was used to describe the prevalence and content of written ethics policies for competent terminally ill, incompetent terminally ill, and non-terminally ill patients.
Results: Of the 298 targeted institutions, 81% of hospitals and 62% of nursing homes returned complete questionnaires. Of these, 79% of hospitals and 30% of nursing homes had a written ethics policy on euthanasia. Of hospitals 83% and of nursing homes 85% permitted euthanasia for competent terminally ill patients only in exceptional cases in accordance with legal due care criteria and provisions outlined by the palliative filter procedure. Euthanasia for incompetent terminally ill patients was prohibited by 27% of the hospitals and by 60% of the nursing homes. For non-terminally ill patients, these figures were 43 and 64%, respectively.
Conclusions: Catholic healthcare institutions in Belgium (Flanders) made great efforts to develop written ethics policies on euthanasia. Only a small group of institutions completely prohibited euthanasia. Most of the institutions considered euthanasia to be an option if all possible alternatives (e.g., palliative filter procedure, which contains more rigorous criteria than those in the Belgian Euthanasia Act), have been thoroughly investigated.

Keywords: Euthanasia; Institutional policies; Ethics; Postal survey; Medical end-of-life decisions

1. Introduction

Euthanasia is performed worldwide, regardless of the existence of laws governing it. Of all deaths, euthanasia accounts for 1.70–2.59% in the Netherlands, 1.70 in Australia, 0.30–1.20% in Belgium

* Corresponding author. Tel.: +32 16 33 69 51; fax: +32 16 33 69 52.
E-mail address: Chris.Gastmans@med.kuleuven.be (C. Gastmans).

0168-8510/$ – see front matter © 2005 Elsevier Ireland Ltd. All rights reserved.
doi:10.1016/j.healthpol.2005.09.003

(Flanders), 0.27% in Switzerland, 0.06% in Denmark, and 0.04% in Italy [1–4]. Also, in the US, it is an existing practice [5]. The lack of transparency in practice about the actual care for patients at the end of life care is worrisome [1,5]. In 2002, Belgium became the second country after the Netherlands, to enact a law on euthanasia [6]. During the period preceding the enactment of this law, public hearings were organized by the Belgian Senate. Flemish Catholic healthcare institutions played a significant role in these hearings by directing attention to the importance of the palliative filter procedure [7,8]. The aim of the palliative filter is to assure that all pertinent caregivers (physicians, nurses, palliative care experts) inform one another about the euthanasia request and about all palliative care alternatives: the care for a patient requesting euthanasia should include a consultation with a specialized palliative care team in order to consider the real needs of the patient [7,8]. The Belgian Euthanasia Act, however, does not contain the palliative filter procedure as a due care criterion. Following the enactment of this law, the position of Catholic healthcare institutions garnished a great deal of interest from politicians, caregivers, ethicists, and the public in general.

Although the Belgian Euthanasia Act mainly addresses the responsibilities of doctors, there is a growing awareness that healthcare institutions also bear significant responsibility in rendering these legal regulations into optimal care for patients requesting euthanasia. It is up to the management of a healthcare institution to guarantee and maintain the quality of care for its patients at the end of life—including those who request euthanasia. Caregivers also need adequate support from the management of the healthcare institution where they work [9]. To ensure such support, a critical first step for institutions is to develop a written ethics policy on euthanasia [8,10,11].

In Belgium, euthanasia guidelines were developed by an organization representing Catholic healthcare institutions [8,12], by medical professional associations [13], and by academic research groups [14,15].

To date, concrete data remain unavailable concerning the prevalence and content of written ethics policies on euthanasia in Flemish healthcare institutions. Catholic hospitals and nursing homes represent 56% (47/84) and 33% (251/761), respectively, of the total number of hospitals and nursing homes in Flanders. Thus, given their active role and particular position in the euthanasia debate, it is desirable to have a clear picture of their ethics policies.

Therefore, the aims of the present study are: (1) to determine the prevalence of written ethics policies on euthanasia in comparison with other end-of-life medical decisions in Catholic hospitals and nursing homes in Belgium (Flanders); (2) to describe the content of these policies on euthanasia; and (3) to describe the potential differences in ethics policies on euthanasia between both the Catholic hospitals and nursing homes.

2. Methods

2.1. Design

A cross-sectional descriptive mail survey was used. The present study was conducted as part of a larger survey that examined the written ethics policies concerning end-of-life medical decisions.

2.2. Participants

This research was carried out in Flanders, the Dutch-speaking region of Belgium, where 60% (5.9 million) of the nation's population live. Questionnaires were mailed to the general directors of all Catholic hospitals ($n = 47$) and nursing homes ($n = 251$) in Flanders, since they can be assumed to have a good general view of the written ethics policy on euthanasia that is in force in their institution. The addresses of these institutions were obtained from the 1 January 2003 membership list of Caritas Flanders, an organization that assembles all Catholic healthcare institutions in Flanders.

2.3. Definitions

According to Article 2 of the Belgian Euthanasia Act, *euthanasia* is defined as the intentional termination of life by someone other than the person concerned, at the latter's request [6]. 'Someone other' is understood to be a doctor, and 'termination of life' is understood to be the administration of a lethal dose of medication. This definition is also used in the Dutch Euthanasia Act [16] as well as in the literature [3,11,17,18].

According to the Belgian Euthanasia Act, the physician commits no criminal offence when he has

Table 1
Belgian Euthanasia Act: due care criteria

Requirements that have to be respected by the physician who performs euthanasia in case of competent terminally ill patients (Art 3.2), non-terminally ill patients (Art 3.3), and incompetent terminally ill patients (Art 4.2).
The physician must (Art 3.2):
inform the patient about their condition of health and their life expectancy; discuss with the patient their request for euthanasia and the possible therapeutic and palliative courses of actions and their consequences;
be certain of the patient's constant physical or mental suffering and of the durable character of their request;
consult another physician about the serious and incurable character of the disorder and inform them about the reasons for this consultation; inform the patient about the result of this consultation;
discuss the request with the nursing team or its members;
discuss the patient's request, if the patient so desires, with relatives appointed by the patient;
be certain that the patient has had the opportunity to discuss his/her request with the persons that he/she wanted to meet
If the physician believes the patient is clearly not expected to die in the near future, he/she must also (Article 3.3):
consult a second physician, who is a psychiatrist or a specialist in the disorder in question, and inform him/her of the reasons for such a consultation;
allow at least 1 month between the patient's written request and the act of euthanasia
The physician who performs euthanasia, in consequence of an advance directive, he/she must (Article 4.2):
consult another physician about the irreversibility of the patient's medical condition and inform him/her about the reasons for this consultation;
if there is a nursing team that has regular contact with the patient, discuss the content of the advance directive with that team or its members;
if a person taken in confidence is designated in the advance directive, discuss the request with that person;
if a person taken in confidence is designated in the advance directive, discuss the content of the advance directive with the relatives of the patient designated by the person taken in confidence

reassured himself that all conditions (Art. 3.1) are fulfilled and when he has respected the due care criteria provided in this Act. These conditions and procedures differ when euthanasia is requested by competent persons (Art. 3.2), by persons no longer able to express their will (i.e., incompetent) (Art. 4.2), and by persons clearly not expected to die imminently (i.e., not terminally ill) (Art. 3.3) (Table 1) [6].

The *palliative filter procedure* is defined as prior consultation with a specialized palliative care team after a euthanasia request has been formulated by the patient; its goal is to thoroughly discuss the concrete possibilities of palliative care [7].

In the present study, *written ethics policy* is defined as the written agreements (procedures, guidelines, protocols, etc.) authorized by the management of a healthcare institution to guide caregivers when approaching a problem that includes a decision-making process and/or phased plan [17].

2.4. Questionnaire

The questionnaire was based on a Dutch semi-structured questionnaire [10,17]. Although The Netherlands and Flanders share the same language as well as a similar culture and history, we adapted some parts of the questionnaire to accommodate legal, ethical, and organizational differences on healthcare and euthanasia. To meet the Belgian legal context, we refined the questionnaire to encompass questions that specifically address the three patient categories (competent, incompetent, and non-terminally ill). To guarantee the content validity of the revised questionnaire, the alterations we made were based on a detailed review of the literature [1,3,8,13,18–20]. The questionnaire's face validity was assessed by presenting the adopted questionnaire to the general directors of three institutions and to six Belgian experts in the area of medical end-of-life decisions.

The revised questionnaire consisted of 52 questions grouped into one general and five specific sections. The general section consisted of questions about the type of healthcare institution and the presence of channels for ethical discussion. The five specific sections consisted of questions about prevalence and content of written ethics policies on: (1) euthanasia; (2) assisted suicide; (3) withdrawing or withholding life-sustaining treatment; (4) symptom and pain relief; and (5) palliative

sedation. The present article focuses on questions relating to the prevalence and the content of written ethics policies on euthanasia.

2.5. Procedure

Data were collected between 1 October 2003 and 15 February 2004. The general directors of all Catholic hospitals and nursing homes received the questionnaire by mail and were asked to fill it in and return it. After 5 weeks, a reminder was sent. The questionnaire provided an anonymity option for the responder, ensuring that the information returned to us could in no way lead to the identification of individual healthcare institutions. The general directors were given assurances that the information they provided would be used for research purposes only and that the research would in no way lead to legal consequences for the participants.

2.6. Ethical considerations

The ethics committee of Caritas Flanders approved the study and gave us written consent to carry out our survey. Participation of the institutions was voluntary. The strictly confidential treatment of the data was guaranteed by the researcher (CG). Returning the completed questionnaire was interpreted as informed consent to participate in the study.

2.7. Analyses

The data were analysed in terms of percent frequency for the participating hospitals and nursing homes. Chi-square with the Yates continuity correction or Fisher Exact was calculated to assess whether differences between hospitals and nursing homes were statistically significant; $P < 0.05$ was considered as significant.

When the policy of a healthcare institution prohibited euthanasia for all three categories of patients – competent terminally ill, incompetent terminally ill, and non-terminally ill patients – we labelled the policy as *complete prohibition of euthanasia*. When the policy prohibited euthanasia for one or two categories of patients, we labelled the policy as *partial prohibition of euthanasia*. Finally, when the policy permitted euthanasia for all categories of patients, we labelled the policy as *no prohibition of euthanasia*.

3. Results

3.1. Response

Of the 298 institutions surveyed, 194 (65%) returned a completed questionnaire. The response from hospitals and nursing homes was 81% (38/47) and 62% (156/251), respectively. A number of institutions opted to suspend their anonymity when returning the questionnaire. This made it possible to determine the geographical location of 29 (76%) of the participating hospitals and 103 (66%) of the participating nursing homes. These institutes were distributed throughout all five provinces of Flanders.

3.2. Prevalence of written ethics policies on euthanasia

Of the hospitals 79% and of the nursing homes 30% had a written ethics policy on euthanasia. Compared with policies dealing with other end-of-life medical decisions, ethics policies on euthanasia were more prevalent in both hospitals and nursing homes (Table 2).

Of the hospitals 95% and of the nursing homes 23% had an ethics committee. Nursing homes with an ethics committee had written ethics policies on euthanasia more often than those without (Table 3).

The written ethics policy on euthanasia of 77% of the hospitals and 87% of the nursing homes represented

Table 2
Prevalence of written ethics policies on euthanasia and other end-of-life medical decisions in Flemish Catholic hospitals and nursing homes

	Hospitals, No (%) ($n = 38$)	Nursing homes, No (%) ($n = 156$)	P
Euthanasia	30 (79)	47 (30)	<0.001
Assisted suicide[†]	0 (0)	1 (1)	1.00[*]
Withdrawing or withholding life-sustaining treatment	28 (74)	35 (22)	<0.001
Symptom or pain control	8 (21)	24 (15)	0.55
Palliative sedation	12 (32)	14 (9)	0.001

[*] Fisher Exact Test was calculated if the expected value of a particular cell was <5.

[†] Assisted suicide is not regulated by law in Belgium.

Table 3
Prevalence of written ethics policies on euthanasia in Flemish Catholic Hospitals and nursing homes with and without an ethics committee

	No. (%)	P
Euthanasia		
In hospitals with ethics committee ($n=36$)	29 (81)	0.38*
Without ethics committee ($n=2$)	1 (50)	
In nursing homes with ethics committee ($n=35$)	24 (69)	<0.001
Without ethics committee ($n=121$)	23 (19)	

* Fisher Exact Test was calculated if the expected value of a particular cell was <5.

one component of a broader policy addressing dying with dignity (Table 4). A major part of these hospitals (78%) had in this broader policy also a policy on withdrawing or withholding life-sustaining treatment compared with 34% of the nursing homes, and a minor part had a policy on symptom or pain control and palliative sedation (Table 4).

In 67% of the hospitals and in 83% of the nursing homes, the ethics policies were formulated in 2003 (Table 4). In healthcare institutions without a written ethics policy, the general directors of 75% of the hospitals and 50% of the nursing homes reported that they were either in the process of drafting a policy or had plans to do so in the future (Table 4).

3.3. Content of written ethics policies on euthanasia

A summary of the content of ethics policies on euthanasia is shown in Table 5. None of the healthcare institutions we surveyed permitted euthanasia without restrictions; consequently, euthanasia was only allowed under strict conditions. Of the institutions that had a written ethics policy on euthanasia, 1 hospital (3%) and 6 nursing homes (13%) had a policy that completely prohibited euthanasia; 15 hospitals (50%) and 27 nursing homes (57%) had a policy that partially prohibited euthanasia; and 14 hospitals (47%) and 14 nursing homes (30%) had a policy that did not prohibit euthanasia.

In a minority of the hospitals (7%) and nursing homes (13%), euthanasia was prohibited for *competent terminally ill patients*, primarily because euthanasia conflicted with the "Christian values of the institution"; another frequent reason was "unconditional respect for life and responsibility for gravely ill per-

Table 4
Policy, date, and plans for the development of written ethics policies on euthanasia in Flemish Catholic hospitals and nursing homes

	Hospitals No. (%)	Nursing homes No. (%)	P
Euthanasia policy is part of broader policy on dignified death	$n=30$	$n=47$	
Yes	23 (77)	41 (87)	0.37
No	7 (23)	6 (13)	0.37
In this broader policy, next to euthanasia there is a policy on	$n=23$†	$n=41$†	
Assisted suicide	0 (0)	1 (2)	1.00*
Withdrawing or withholding life-sustaining treatment	18 (78)	14 (34)	0.001
Symptom or pain control	5 (22)	11 (27)	0.768
Palliative sedation	8 (35)	5 (12)	0.050
Euthanasia policy was formulated in	$n=30$	$n=47$	
2002	10 (33)	8 (17)	0.17
2003	20 (67)	39 (83)	0.17
Future plans of healthcare institutions that had no euthanasia policy at time of survey	$n=8$	$n=109$	
In the process of developing an ethics policy	4 (50)	21 (19)	0.07*
Have concrete plans to develop an ethics policy in the future	2 (25)	34 (31)	1.00*
Have no plans to develop an ethics policy	2 (25)	54 (50)	0.27*

* Fisher Exact Test was calculated if the expected value of a particular cell was <5.
† Different response rates to the questions are reported.

Table 5
Content of written ethics policies on euthanasia in Flemish Catholic hospitals and nursing homes

	Hospitals ($n = 30$) No. (%)	Nursing homes ($n = 47$) No. (%)	P
Policy of healthcare institution on euthanasia			
Complete prohibition[†]	1 (3)	6 (13)	0.24[*]
Partial prohibition[‡]	15 (50)	27 (57)	0.69
No prohibition[a]	14 (47)	14 (30)	0.21
Euthanasia in competent, terminally ill patients			
Not permitted	2 (7)	6 (13)	0.47[*]
Permitted, only in exceptional cases in accordance with legal due care criteria and palliative filter procedure	25 (83)	40 (85)	1.00[*]
Permitted, in accordance with legal due care criteria	3 (10)	1 (2)	0.29[*]
Permitted without restrictions	0 (0)	0 (0)	NA
Euthanasia in incompetent terminally ill patients			
Not permitted	8 (27)	28 (60)	0.01
Permitted, only in exceptional cases in accordance with legal due care criteria and palliative filter procedure	19 (63)	17 (36)	0.04
Permitted, in accordance with legal due care criteria	3 (10)	2 (4)	0.37[*]
Permitted without restrictions	0 (0)	0 (0)	NA
Euthanasia in non-terminally ill patientsa			
Not permitted	13 (43)	30 (64)	0.13
Permitted, only in exceptional cases in accordance with legal due care criteria and palliative filter procedure	16 (53)	17 (36)	0.21
Permitted, in accordance with legal due care criteria	1 (3)	0 (0)	0.39[*]
Permitted without restrictions	0 (0)	0 (0)	NA

NA = not applicable.

[*] Fisher Exact Test was calculated if the expected value of a particular cell was <5.

[†] *Complete euthanasia prohibition:* euthanasia prohibited for all patient categories (competent terminally ill patients, incompetent terminally ill patients, non-terminally ill patients).

[‡] *Partial euthanasia prohibition:* euthanasia prohibited for one or two patient categories.

[a] *No prohibition:* euthanasia permitted for all patient categories.

sons". In 27% of the hospitals and 60% of the nursing homes, euthanasia was prohibited for *incompetent terminally ill patients*. Frequently mentioned reasons were "frequent problems interpreting advance directives, the irreversibility of euthanasia, the extremely weak position of incompetent patients", and the "Christian values of the institution". In 43% of the hospitals and 64% of the nursing homes, euthanasia was prohibited for *non-terminally ill patients*. The management of these institutions mentioned as reasons for this prohibition the "Christian values of the institution" and "the need for further investigation of therapeutic options for non-terminally ill patients".

In a majority of the hospitals (83%) and nursing homes (85%), euthanasia for *competent terminally ill patients* was permitted only in exceptional cases, in accordance with legal due care criteria and after implementation of the palliative filter procedure.

3.4. Procedural aspects of written ethics policies on euthanasia

The general directors of 42% of the hospitals reported that their institution's ethics policy concentrated on the medical/technical aspects of euthanasia; in none of the nursing homes this was the case (Table 6). The written ethics policies of hospitals more frequently contained a clause requiring that euthanasia be reported to the Federal Control and Evaluation Committee than did the ethics policies of nursing homes. In 50% of the hospitals and 60% of nursing homes, the ethics policies explicitly addressed how to deal with the patients' advance directives. In 93% of the hospitals and 74% of nursing homes, the ethics policies explicitly addressed issues dealing with the conscientious objections of doctors. In such cases, referral to another physician within the same institution was an often-mentioned option.

Table 6
Procedural items described in written ethics policies on euthanasia in Flemish Catholic hospitals and nursing homes

	Hospitals No. (%)	Nursing homes No. (%)	*P*
Items are described in ethics policies	$n = 26^{\dagger}$	$n = 35^{\dagger}$	
Medical/technical aspects	11 (42)	0 (0)	<0.001*
Reporting before the performance of euthanasia to management	7 (27)	29 (83)	0.009
Reporting after the performance of euthanasia to management	6 (23)	2 (6)	0.02*
Reporting after the performance of euthanasia to Federal Control and Evaluation Committee	23 (88)	9 (26)	<0.001
Ethics policy addresses advance directives	$n = 30$	$n = 47$	
Yes	15 (50)	28 (60)	0.55*
No	15 (50)	19 (40)	0.55*
Ethics policy addresses conscientious objections of physicians	$n = 30$	$n = 47$	
Yes	28 (93)	35 (74)	0.07
No	2 (7)	12 (26)	0.07
Procedure for handling conscientious objections of physicians	$n = 25^{\dagger}$	$n = 32^{\dagger}$	
Referral to another physician within institution	22 (88)	20 (63)	0.06
Referral to another physician outside institution	10 (40)	7 (22)	0.23
Other	2 (8)	6 (19)	0.44*

* Fisher Exact Test was calculated if the expected value of a particular cell was <5.
† Different response rates to the questions are reported.

4. Discussion

Our study shows a high (hospitals 79%) to moderate (nursing homes 30%) prevalence of written ethics policies on euthanasia in Catholic healthcare institutions in Belgium (Flanders). This prevalence will likely increase in the future, since the Euthanasia Act only recently (2002) came into force; furthermore, 75% of the Catholic hospitals and 50% of the nursing homes that did not have a written euthanasia policy at the time of our survey reported that they were either developing a policy or were planning to develop one in the future. With the exception of Belgium and the Netherlands, euthanasia guidelines have received little scholarly attention until now [1,5,21–24]. Yet, euthanasia requests are also formulated and euthanasia is also carried out in countries that do not have specific laws governing it [1,2,5,24]. Developing ethics policies that address end-of-life medical decisions and more specifically euthanasia can lead to the careful planning of practical clinical guidelines (e.g., how to deal with euthanasia requests), can prevent certain undesirable practices (e.g., termination of life without request), can clarify the responsibilities of all parties involved (e.g., preventing delegation of performance of euthanasia to nurses), and can thus create an environment by which both caregivers and patients can have a clear idea of what to expect when euthanasia issues arise [9,10,25].

In Flemish Catholic nursing homes, the development of written ethics policies on euthanasia has not advanced as far as in hospitals. One possible reason for the lower prevalence of ethics policies in nursing homes is that hospitals in Belgium are required by law to have an ethics committee, which possesses the necessary means and know-how to carry out and support policy development in a structured manner [26]. Indeed, our study found that Catholic nursing homes with ethics committees more often had a written euthanasia policy than did nursing homes without such a committee. A second reason is that euthanasia occurs less frequently in nursing homes than in hospitals. Between October 2002 and December 2003, 54% of the registered cases of euthanasia in Belgium were performed in hospitals, whereas only 5% were performed in nursing homes [27]. The low incidence of registered cases of euthanasia in nursing homes can likely provide an explanation for why few nursing homes have an ethics policy which focuses explicitly on the medical technical aspects of euthanasia or on reporting euthanasia to the Federal Control and Evaluation Committee. The finding that, in both Catholic hospitals and nursing

homes, the prevalence of the ethics policy on euthanasia is higher than the prevalence of other medical decisions concerning the end of life is perhaps a reflection of the fact that the legal and ethical debate in Flanders was in recent years primarily directed toward euthanasia. However, this does not alter the fact that most general directors in Catholic hospitals and nursing homes reported that the ethics policy on euthanasia constituted part of a broader policy pertaining to dying with dignity.

The ethics policies of the Catholic healthcare institutions stipulated that the performance of euthanasia was subject to clear conditions. For competent terminally ill patients, policies prohibiting euthanasia were relatively rare in both hospitals and nursing homes (7 and 13%, respectively), comparable to Dutch – be it older – data [17]. Flemish Catholic hospitals and nursing homes (83 and 85%, respectively) considered euthanasia an option only in exceptional cases, when both legal due care criteria and the palliative filter procedure had been fulfilled in cases of competent terminally ill patients. The euthanasia law contains a due care criterion stipulating that the attending physician must discuss palliative care possibilities with the patient (Art. 3.2) (Table 1) [6]. However, most Flemish Catholic healthcare institutions considered Article 3.2 to be insufficient, since in their view, not all doctors are familiar with all the possibilities offered by various palliative care facilities. Moreover, they believed that euthanasia can only be justified when an *obligatory* consultation takes place with a palliative care *expert*.

The palliative filter procedure that occupies a central place in the ethics policies of Catholic healthcare institutions originated from the Flanders Palliative Care Federation, a pluralistic organization that assembles various palliative care initiatives [7]. The Federation posits that an extensive network of palliative care facilities can provide adequate solutions to some of the motives underlying euthanasia requests, thus creating room for the discussion of alternative ways of dying, which in turn may reduce the number of euthanasia requests. This view is shared by different international studies [28–31]. The plea for the palliative filter procedure is only credible if on the one hand, a sufficiently strongly developed and accessible palliative care structure exists and on the other hand, if it is not used as an impenetrable barrier making euthanasia practically impossible to perform. In Belgium, the development of palliative care preceded the euthanasia debate [7]. As a result, Belgian palliative care played a very active role in the euthanasia debate. The Belgian euthanasia debate itself functioned as a lever that facilitated the further development of palliative care, as is illustrated by the law on palliative care that was approved at the same time as the euthanasia law [32]. A comprehensive palliative care framework was set up nationwide, which may make the emphasis of Catholic healthcare institutions on the palliative filter procedure realistic and plausible [12].

Euthanasia requests, via advance directives, from incompetent terminally ill patients, and even more for non-terminally ill patients encounter much more resistance from Catholic healthcare institutions, especially from nursing homes. This resistance is reflected in international literature [33,34].

Because our study is the first in Belgium to systematically examine and catalog ethics policies on euthanasia in Catholic healthcare institutions, there are no national data for comparison. Extending this research to non-Catholic healthcare institutions would add significantly to our study, permitting us to determine whether these institutions differ in their ethics policies on euthanasia. In 1996, Haverkate and van der Wal reported a correlation between the religious affiliation of nursing homes and the content of their ethics policies on euthanasia [17]. In their study, nursing homes that prohibited euthanasia more often had a religious affiliation. Our study shows that only a small minority of Catholic healthcare institutions in Flanders completely prohibit euthanasia. The willingness to deal with euthanasia requests within the institution is confirmed by our finding that, in cases of conscientious objections from a doctor, most Catholic institutions choose to refer the patient requesting euthanasia to another doctor at the same institution. These findings perhaps reflect developments in the field of Catholic healthcare institutions in Flanders. The statements of the Roman Catholic Magisterium on euthanasia [35] are, in Catholic healthcare institutions, no longer generally accepted as the legitimate foundation for developing their own ethics policies. On the other hand, almost all Catholic healthcare institutions regard the mere application of the due care criteria provided for in the law as insufficient to justify euthanasia. By introducing the additional condition of a palliative filter procedure, they aim at a very restrictive application of the euthanasia law.

4.1. Methodological issues

Response from hospitals (81%) was very high. Because all Catholic hospitals in Flanders were invited to participate in our study and because all provinces of Flanders returned questionnaires, we consider our results to be representative of all Flemish Catholic hospitals. Response from nursing homes was lower (62%) but satisfactory [36]. Nevertheless, we will have to consider possible non-response bias, which might distort the results from the nursing homes. Nursing homes that were familiar with the problems surrounding euthanasia were perhaps more inclined to take part in our study.

In the present study, we approached only the general directors of Flemish Catholic hospitals and nursing homes. As a consequence, our findings reflect only one perspective on written euthanasia policies. Further research into the content of ethics policies (procedures, guidelines, protocols, etc.) will shed additional light to this picture. In addition, it will be necessary to verify how these policies are actually implemented within the institution and whether these policies contribute to providing better ethical care.

References

[1] van der Heide A, Deliens L, Faisst K, et al. End-of-life decision-making in six European countries: descriptive study. The Lancet 2003;362:345–50.

[2] Kuhse H, Singer P, Baume P, et al. End-of-life decisions in Australian medical practice. Medical Journal of Australia 1997;166:191–6.

[3] Deliens L, Mortier F, Bilsen J, et al. End-of-life decisions in medical practice in Flanders, Belgium: a nationwide survey. The Lancet 2000;356:1806–11.

[4] van der Maas PJ, van der Wal G, Haverkate I, et al. Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands, 1990–1995. New England Journal of Medicine 1996;335:1699–705.

[5] Magnusson RS. Euthanasia: above ground, below ground. Journal of Medical Ethics 2004;30:441–6.

[6] Belgian Ministry of Justice. Wet betreffende de euthanasie [The Belgian Euthanasia Act]. Belgian Law Gazette of 22 June 2002. Available at: http://www.ejustice.just.fgov.be. Accessed 25 May 2005.

[7] Broekaert B, Janssens R. Palliative care and euthanasia: Belgian and Dutch perspectives. In: Schotsmans P, Meulenbergs T, editors. Euthanasia and palliative care in the low countries. Leuven, Paris/Dudley, MA: Peeters; 2005. p. 35–70.

[8] Gastmans C. Caring for a dignified end of life in a Christian health-care institution: the view of Caritas Catholica Vlaanderen. In: Schotsmans P, Meulenbergs T, editors. Euthanasia and palliative care in the low countries. Leuven, Paris/Dudley, MA: Peeters; 2005. p. 205–26.

[9] De Beer T, Gastmans C, Dierckx de Casterlé B. Involvement of nurses in euthanasia: a review of the literature. Journal of Medical Ethics 2004;30:494–8.

[10] Haverkate I. Policies and guidelines on medical decisions concerning the end of life in Dutch health care. Amsterdam: Thela Thesis, 1999.

[11] Dutch State Commission on Euthanasia. Rapport van de Staatscommissie Euthanasie. Deel 1: Advies [Report of the State Commission of Euthanasia: Part 1: Advice]. 's Gravenhage: Staatsuitgeverij, 1985.

[12] Gastmans C, Van Neste F, Schotsmans P. Facing requests for euthanasia: a clinical practice guideline. Journal of Medical Ethics 2004;30:212–7.

[13] National Council of Physicians. Advies betreffende palliatieve zorg, euthanasie en andere medische beslissingen omtrent het levenseinde [Advice concerning palliative care, euthanasia and other medical end-of-life decisions]. Tijdschrift van de Nationale Raad Orde der Geneesheren 2003;11:5–9.

[14] Vermylen J, Schotsmans P. Ethiek in de kliniek: 25 jaar adviezen van de Commissie Medische Ethiek, Faculteit Geneeskunde, K.U. Leuven [Ethics in clinical practice: 25 years of Advice from the Medical Ethics Committee, Faculty of Medicine, K.U. Leuven]. Leuven: Universitaire Pers, 2000. p. 101–12.

[15] Deschepper R, Vander Schichele R, Mortier F, et al. Zorgzaam thuis sterven: een zorgleidraad voor huisartsen [Carefully Dying at Home: A Care Guideline for General Practitioners]. Gent: Academia Press, 2003.

[16] Dutch Law Gazette. Toetsing van levensbeëindiging op verzoek en hulp bij zelfdoding [Evaluation of ending life on request and assistance in suicide]. Wet in Nederlands Staatsblad nr 194 [Law in Dutch Law Gazette nr 194]. 2001.

[17] Haverkate I, van der Wal G. Policies on medical decisions concerning the end of life in Dutch health care institutions. JAMA 1996;275:435–9.

[18] National Advisory Committee on Bioethics, Advies nr. 1 betreffende de wenselijkheid van een wettelijke regeling van euthanasia [Advice nr. 1 concerning the desirability of a legal regulation of euthanasia]. Bioethica Belgica 1998;May:2–6.

[19] National Advisory Committee on Bioethics, Advies nr. 9 betreffende het levensbeëindigend handelen bij wilsonbekwamen [Advice nr. 9 concerning the action of termination of life in incompetent terminally ill patients]. Bioethica Belgica 1999;June:2–19.

[20] Nys H. A Comparative analysis of the law regarding euthanasia in Belgium and The Netherlands. Ethical Perspectives 2002;9:73–85.

[21] Drickamer MA, Lee MA, Ganzini L. Practical issues in physician-assisted suicide. Annals of Internal Medicine 1997;126:146–51.

[22] Young EW, Marcus FS, Drought T, et al. Report of the Northern California Conference for Guidelines on Aid-in-Dying: definitions, differences, convergences, conclusions. Western Journal of Medicine 1997;166:381–8.

[23] Heilig S, Brody R, Marcus F, et al. Physician-hastened death: Advisory guidelines for the San Francisco Bay Area from the

Bay Area Network of Ethics Committees. Western Journal of Medicine 1997;166:370–8.
[24] Meier DE, Emmons CA, Wallenstein S, et al. A national survey of physician-assisted suicide and euthanasia in the United States. New England Journal of Medicine 1998;338:1193–201.
[25] Miles SH, Ryden MB. Limited-treatment policies in long-term care facilities. Journal of the American Geriatrics Society 1985;33:707–11.
[26] Nys H. Ethics committees in Belgium. European Journal of Health Law 1995;2:175–6.
[27] Federal Control and Evaluation Committee on Euthanasia. Eerste verslag van de Wetgevende Kamers, 22 September 2002 to 31 December 2003 [First report of the Constitutive Chamber, 22 December 2002 to 31 December 2003]. Brussels, 2004.
[28] Back AL, Wallace JI, Straks HE, et al. Physician-assisted suicide and euthanasia in Washington State: patient requests and physician responses. JAMA 1996;275:919–25.
[29] Oxenham D, Boyd K. Voluntary euthanasia in terminal illness. In: Clark D, Hockley J, Ahmedzai S, editors. New themes in palliative care. Buckingham, PA: Open University Press; 1997. p. 275–87.
[30] Doyle D, Hanks G, MacDonald N, editors. Oxford textbook of palliative medicine. 2nd ed. Oxford: Oxford University Press; 1998.
[31] Caplan A, Snyder L, Faber-Langendoen K. The role of guidelines in the practice of physician-assissted suicide. Annals of Internal Medicine 2000;132:476–81.
[32] Belgian Ministry of Justice. Wet betreffende de palliatieve zorg [The Belgian Palliative Care Act]. Belgian Law Gazette of 22 June 2002. Available at: http://www.ejustice.just.fgov.be. Accessed 25 May 2005.
[33] Gunderson M, Mayo DJ. Restricting physician-assisted death to the terminally ill. Hastings Centre Report 2000;30:17–23.
[34] Fagerlin A, Schneider CE. Enough: the failure of the living will. Hastings Centre Report 2004;34:30–42.
[35] Congregation for the Doctrine of the Faith. Declaration on euthanasia. Origins 1980;10:154–7.
[36] Polit DF, Beck CT. Nursing research: principles and methods. 7th ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2004. p. 366–7.